

**Women
to Women, P.C.**
Complete OB/GYN Care

www.womentowomenobgyncare.com

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Dear Patient:

The providers and staff of Women to Women, PC would like to take this opportunity to welcome you to our practice. We anticipate you may have many questions about your condition, what to expect from your visits with us and how we will work with your other health care providers. It is our belief, that by working together we may achieve the best possible outcome for you. We are happy to assist you to ensure you receive the most comprehensive, up to date treatment in an environment that fosters understanding, compassion, consideration and respectful care.

We feel open and effective communication is essential in ensuring a pleasant experience with our practice. As such, we have prepared the "Patient Rights and Responsibilities" and Office Procedures/Patient Financial Responsibilities documents to assist you in understanding how our practice works and how you may best work with us. We have also included an article *Understanding Your Insurance Coverage* to assist you with insurance related issues. We encourage you to familiarize yourselves with these materials. Please feel free to seek assistance from our Staff, should you have questions regarding these documents.

To facilitate your first visit to our practice, please complete and sign the *Health History Form*, the *Acknowledgment of Receipt of the Patients Rights and Responsibilities Form*, and the *patient Registration Form*. Please bring these completed forms along with your insurance card and photo identification 15 minutes early for your first appointment, so that we may prepare your medical record.

We are pleased and honored you have chosen our practice. Thank you for placing your trust and confidence in us. We look forward to assisting you in your care.

Sincerely,

Women to Women, PC

PATIENT RIGHTS AND RESPONSIBILITIES

We believe that healthcare delivery is a partnership between provider and patient. In that spirit of cooperation, we are committed to providing with you information to assist you as we work together to facilitate your care. **As a patient of Women to Women, PC, you have the right to:**

1. Receive considerate and respectful care at all times.
2. Expect that your interactions with our office and information related to your care will be handled confidentially.
3. Obtain complete and current information concerning your medical condition, explained to you in terms that can be easily understood.
4. Participate in decisions regarding your care and treatment.
5. Receive information about the Practice and your rights and responsibilities as a patient.
6. Know the identities and professional status of the staff assisting or treating you.
7. Expect reasonable safety in so far as medical services and environment are concerned.
8. Be accompanied by an individual/chaperone during medical appointments, tests and treatment.
9. Bring forward issues surrounding your care or treatment, without fear of retribution or discrimination and expect issues to be fairly investigated, with follow up/resolution in a timely manner.
10. Receive, with written permission from you or your authorized representative, access to your medical records and any information that pertains to you, except as required or permitted by law.
11. Refuse treatment, providing you accept the responsibility and consequences of your decision.
12. Receive an explanation of your bill, regardless of the source of payment.

As a patient of Women To Women, PC you are asked to:

1. Provide your health care professional with accurate and complete information regarding your personal health, medical history and changes in your condition.
2. Maintain your relations with other treating physicians.
3. Keep scheduled appointments or cancel with as much advance notice as possible.
4. Follow the instructions and treatment plan recommended by your health care professionals.
5. Speak with your health care professional should you have questions or if you do not understand or agree with your medical treatment.
6. Take responsibility for your health by actively engaging in behaviors which will promote a healthy lifestyle.
7. Familiarize yourself with and adhere to the Practice's "General Office Procedures and Patient Financial Responsibilities."
8. Understand your financial responsibilities related to your care and treatment and maintain a current account with the Practice.

Patient Medical History

Patient Name		Date of Birth	Age	Today's Date:		
<input type="checkbox"/> New Patient		<input type="checkbox"/> Established Patient		<input type="checkbox"/> Consultation		
Reason for visit:						
Current Medications:						
Name/Dosage		Name/Dosage				
1.		3.				
2.		4.				
Please Circle if You Have Had Any of the Following:						
Endometriosis	Cancer	Asthma	Urinary Tract Infections	Lupus		
Uterine Fibroids	Thyroid Disease	HIV	Depression	Hepatitis		
PCOS	Irritable Bowel	Migraine Headaches	Heart Attack	AIDS		
Bladder Incontinence	Diabetes	High Blood Pressure	Seizures			
OTHER: _____						
Have you ever used the following:						
Smoke Cigarettes: <input type="checkbox"/> Yes <input type="checkbox"/> No		Drink Alcohol: <input type="checkbox"/> Yes <input type="checkbox"/> No		Marijuana, cocaine, etc.: <input type="checkbox"/> Yes <input type="checkbox"/> No		
Currently: <input type="checkbox"/> Yes <input type="checkbox"/> No		Currently: <input type="checkbox"/> Yes <input type="checkbox"/> No		Currently: <input type="checkbox"/> Yes <input type="checkbox"/> No		
Do you exercise at least three days a week? <input type="checkbox"/> Yes <input type="checkbox"/> No						
Are you allergic to any medications? <input type="checkbox"/> Yes (If yes, list below) <input type="checkbox"/> No						
Hospitalization History: Please list any hospital admissions or operations you have had:						
Date	Procedure			Reason for Surgery or Hospitalization		
Family History: Please list relatives with the following medical problems:						
Heart Disease (High Blood Pressure, Stroke, Heart Attack) _____						
Diabetes _____		Thyroid Disease _____		Breast Cancer _____		
Other Cancer (what type) _____			Osteoporosis _____			
Obstetrical History: Please list ALL pregnancies (including miscarriages and abortions)						
Date	Weeks Pregnant	WT	Sex	Vaginal or C-Section	Hospital	Complications
Gynecological History:						
Date of last Pap smear: _____			Date of last mammogram: _____			
Date of abnormal Pap Smear: _____			Date of last DEXA SCAN: _____			
Results: _____						
Treatment: _____						
Date of last NORMAL period: _____ How many days do you bleed? _____ Are you menopausal? _____						
Age at first period? _____ Do you bleed in between periods? _____ Do you get hot flashes? _____						
How often do you get your period? _____ Do you have pain with your periods? _____ Night Sweats? _____						
Have you ever had intercourse? <input type="checkbox"/> Yes <input type="checkbox"/> No			Heterosexual _____ Homosexual _____ Bisexual _____			
Are you having pain with intercourse? <input type="checkbox"/> Yes <input type="checkbox"/> No			Are you having bleeding after intercourse? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Have you ever had the following:						
Chlamydia: _____ Gonorrhea: _____ Herpes: _____ PID: _____ Genital Warts (HPV): _____ Syphilis: _____						
HIV: _____ Trichomonas: _____						
Have you ever been sexually assaulted? <input type="checkbox"/> Yes <input type="checkbox"/> No			Has your partner verbally or physically abused you? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Contraceptive History:						
What method are you using now? _____						
What methods have you used in the past? _____						
Patient Signature:				Date:		

